

Individual and Family Plans

Outline of Coverage



Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

**Discover the Choice, Affordability, and Freedom
of Individual and Family Plans**



Introduction

Thank you for your interest in Regence BlueCross BlueShield of Utah's (Regence BCBSU) Individual BlueChoices plans and Regence HSA Healthplan for individuals and families. Individual BlueChoices is not only affordable, but also offers flexibility and freedom in selecting the right coverage for you and your family members. Regence HSA Healthplan allows you to combine your health plan with a Health Savings Account (HSA) at the financial institution of your choice, or with Regence Financial Services, powered by BlueBank.*

Quite simply, our individual and family plans offer a unique line of products that give you more choice in health care networks and benefits than ever before.

** Banking services provided by Blue Healthcare Bank, a DBA of Health Benefit Bank, Member FDIC.*

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Individual BlueChoices Outline of Coverage

General Information

This outline of coverage is a brief description of the important features of your Health Care Agreement. This outline of coverage is not the insurance contract and only the actual provisions of the Health Care Agreement will control. After you are accepted, a Health Care Agreement and member card will be mailed to you. Please read your Health Care Agreement carefully. The Health Care Agreement itself sets forth in detail the rights and obligations of both you and Regence BCBSU. It is, therefore, important that you READ YOUR HEALTH CARE AGREEMENT CAREFULLY.

Major Medical Coverage is designed to provide coverage for major hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any Deductibles, Copayments, Coinsurance, or other limitations which may be set forth in the Health Care Agreement.

This is NOT a Medicare Supplement Contract

If you or a family member become eligible for Medicare, you should review the Medicare Supplement Buyer's Guide available from Regence BCBSU. If you choose to continue coverage under the Health Care Agreement and Medicare, the benefits of the Health Care Agreement shall be reduced by any amounts paid by Medicare.

Your Rights to Waive PEC Waiting Periods

Federal and state health insurance regulations provide portability (reduction or elimination of the pre-existing condition (PEC) waiting period because of prior coverage) for certain individuals and families who meet the established guidelines. Refer to Special Notices on page 27 in this booklet or contact Individual Marketing at 1 (888) Regence. Contact your insurance agent or Regence BCBSU for more information about these regulations and how they may affect your rights to receive credit toward your PEC waiting period.

What is Covered

Benefits are available for these services and supplies when Medically Necessary.

Inpatient and Outpatient Hospital/Skilled Nursing Facility

- Semi-private room accommodations
- Ancillary services and supplies
- Emergency room services
- X-ray and laboratory services
- Inpatient rehabilitation

Home Health Care/Home Infusion Therapy Services

- Home Health Care services provided in the Enrollee's home
- Home Infusion Therapy services provided in the Enrollee's home
- Other services and supplies

Physician Services

- Surgical services
- Assistant surgeon services
- Anesthesia services
- Inpatient medical services
- Outpatient medical services
- Diagnostic services
- Chemotherapy
- Radiation therapy
- Outpatient rehabilitation and chiropractic services (physical, speech, and occupational therapies and chiropractic care limited to \$1,500 per Enrollee per Calendar Year)
- Consultations
- Preventive services for adults and children age 6 and over (limited to \$300 per Enrollee per calendar year)
- Dental services for Accidental Injury
- Skilled nursing services
- Dialysis services
- Mental Health Condition (including drug/alcohol use/abuse) services (limited to \$1,500 per Enrollee per calendar year)

Prescription Drugs

\$250, \$500 and \$1,000 Medical Deductible Plans: Outpatient prescription drugs are covered under a Prescription Drug Rider issued in conjunction with the basic policy. \$2,500, \$5,000, \$7,500 Plans: Outpatient prescription drugs are covered at a coinsurance level after the medical deductible per calendar year has been met. Your member card serves as a discount card at participating pharmacies.

Other Services

- Durable Medical Equipment
- Medical/surgical supplies
- Ambulance services
- Inpatient/Outpatient Maternity Care (subject to \$5,000 copay per pregnancy)

Continued...

Diabetic Supplies and Educational Benefits

Diabetic supplies (including needles, syringes, test strips, lancets, and other disposable diabetic supplies) are covered under a Prescription Drug Rider issued in conjunction with the basic policy, if applicable, or under the basic policy benefit for Durable Medical Equipment and supplies. Diabetic education received through an accredited or certified diabetic education program is also covered.

Transplants

Coverage is available for kidney, cornea, heart, heart/lung, lung, liver, and pancreas transplants, and bone marrow transplants for certain conditions (see the Health Care Agreement for details).

MAT/HSCS

Coverage is available for Myeloablative Therapy (MAT) With Hematopoietic Stem Cell Support (HSCS) For Malignancies. Specific criteria must be met for coverage to be provided. Prenotification is required.

Preventive Services (limited)

- Children through age 5:
 - Ten professional examinations in the first 24 months of life and four professional examinations per child per year from age 2 through age 5 years, including routine diagnostic tests
- Children age 6 through 17:
 - Childhood immunizations covered through age 17 years. \$300 Maximum Benefit limit does not apply
- Adults and children 6 years and older:
 - Maximum Benefit \$300 per Enrollee per Calendar Year
- Enrollees over age 5 years:
 - One routine physical examination each year
 - One Pap smear each year
 - One prostate specific antigen (PSA) test each year for an Enrollee 40 years or older
 - Mammography screening in accordance with the following:
 - › One baseline screening for an Enrollee 35 through 39 years; or
 - › One screening each year for an Enrollee 35 through 39 years with documentation that the Enrollee has an inherited predisposition for cancer of the breast; or
 - › One screening each year for an Enrollee 40 years of age or older
- Enrollee 40 years of age or older:
 - Annual test of the stool for occult blood
 - Sigmoidoscopy or colonoscopy every 5 years
 - Specified adult immunizations
 - One bone density scan each year

Accidental Death Benefit

All Individual BlueChoices plans include a death benefit payable to the estate of the subscriber in the event of death caused by accidental means. Adult subscribers, covered spouses, covered children and juvenile subscribers (under age 18) are eligible for this benefit.

The accidental death benefits are outlined below:

Insured	Death Benefit
Adult Subscriber	\$25,000
Covered Spouse	\$25,000
Covered Dependent Child	\$5,000 per child
Subscriber (under age 18)	\$5,000

Benefits are subject to the terms set forth in the Health Care Agreement.

Limitations

During the 12-month limitation period following the Enrollee's application for coverage, NO BENEFITS will be provided for:

- Pre-existing conditions which are physical or mental conditions (including but not limited to pregnancy), for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to the Effective date;
- Sterilization (e.g., vasectomy, tubal ligation).

We will reduce the duration of the 12 month waiting period by the amount of your combined periods of Creditable Coverage if you have been covered by Qualifying Coverage, provided there is no break in coverage greater than 63 days immediately preceding your application for coverage under this Agreement. Coverage may be concurrent.

Qualifying Coverage means only the following: group coverage (including self-funded plans); individual coverage (including student health plans); S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans (including foreign government and US government plans).

Coverage for Job or Work-Related Claims or Illnesses

Normally, job or work-related claims that are paid under any workers' compensation or employer liability insurance are excluded from coverage under the Health Care Agreement. However, if you are not required by law to be covered under workers compensation insurance, coverage may be available for the cost of care and treatment related to such a claim, in accordance with the terms, conditions, limitations, and exclusions of the Health Care Agreement. Coverage under the Health Care Agreement will be evaluated at the time a claim for such care and treatment is received by Regence BCBSU and may require additional information from you to determine your entitlement to coverage under the Health Care Agreement.

Exclusions

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, or for any direct complications or consequences thereof.

Alternative Care

- Acupuncture and acupressure
- Holistic and homeopathic treatment
- Massage or massage therapy
- Naturopathy
- Faith healing
- Milieu therapy
- Hypnosis
- Sensitivity training
- Behavior modification
- Biofeedback
- Electrohypnosis, electrosleep therapy, or electronarcosis
- Ecological or environmental medicine
- Other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer

Appliances or Restorations Necessary to Increase Vertical Dimension or Restore Occlusion

Automobile Personal Injury Protection Coverage

Services and supplies for the treatment of an Injury or Illness that are the responsibility of any automobile personal injury protection ("PIP") coverage, including:

- Coverage up to the minimum amount required by state or federal law, regardless of whether or not such coverage is in force
- Any amount of coverage carried in excess of the minimum amount required by state or federal law, regardless of whether or not the Enrollee files a claim for benefits under such coverage

Benefits Not Stated

Services and supplies provided for which there is no stated benefit under the Agreement. When a non-covered service or supply is performed or received at the same time as a Covered Service, then only the portion of charges relating to the Covered Service will be considered eligible for payment under this Agreement.

Birth Control/Infertility

Services and supplies in connection with the following:

- Non-prescription contraceptives
- Reversal of voluntary surgically performed sterilization or subsequent re-sterilization
- Artificial insemination or in vitro fertilization
- Infertility, except to the extent Covered Services are required to diagnose such condition
- Fertility drugs and medications

Charges That Exceed Eligible Medical Expenses

Any charge for services and supplies that exceed Eligible Medical Expenses.

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or Reconstructive services and supplies (including direct complications or consequences thereof), including blepharoplasty and otoplasty, except in the case of surgery that is:

- Performed to restore a physical bodily function
- Related to an Accidental Injury
- Related to breast Reconstruction following a Medically Necessary mastectomy to the extent required by law

Cosmetic means services or supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to restore function, but may also be done to approximate a normal appearance.

For the purposes of this Agreement, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

Counseling

Charges for counseling an Enrollee, including the following:

- Marital counseling
- Family counseling
- Educational, social, occupational, or religious counseling
- Counseling in the absence of Illness or Injury
- Counseling with a patient's family, friend(s), employer, school counselor, or school teacher

This exclusion does not apply to services for counseling an Enrollee when incidentally provided, without separate charge, in connection with Covered Services.

Court-Ordered or Court-Related Services/ Services in Connection with Legal Proceedings

Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.

Custodial, Domiciliary and Convalescent Care

Custodial Care, domiciliary care, convalescent care (other than extended care), rest cures, and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the Enrollee's environment.

Custodial Care means care that mainly provides room and board (meals), or if it is for a physically or mentally disabled person who is not receiving care specifically to reduce the disability so that the person can live outside a medical care facility or nursing home. No matter where the person lives, care is considered Custodial Care if it is non-skilled nursing care, training in personal hygiene, other forms of self-care, supervisory care by a Provider, or care provided by a health-care facility licensed by the State of Utah as an assisted living facility, hospice, residential health-care facility, or small health-care facility, or that is similarly licensed by the state in which it is located.

Dental Services

Dental Services, unless the Agreement specifically covers them.

Erectile Dysfunction

Services and supplies for or in connection with erectile dysfunction, regardless of its origin.

Expenses Incurred Before Coverage Begins or After Coverage Ends

Services and supplies incurred before enrollment under the Agreement or after termination under the Agreement.

Experimental or Investigational Services

Experimental or investigational treatments or procedures; and services, supplies, and accommodations provided in connection with experimental or investigational treatments or procedures. A treatment or procedure will be considered experimental or investigational if reasonable and substantial scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical Provider community for a period of 5 years. Our Medical Director will determine whether a treatment or procedure is experimental or investigational. The absence of any alternative treatment or procedure or any effective non-experimental or non-investigational treatment or procedure for an Illness or Injury shall not make or be deemed to make an experimental or investigational treatment or procedure a Covered Service.

Fees, Taxes, Interest, etc.

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales, or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state, or local government, or by another entity, unless required by law.

Foot Care

Foot care, including but not limited to:

- Treatment of corns and calluses
- Trimming of nails (we do cover surgery for ingrown toenails)
- Foot impression casting including x-rays
- Nonsurgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot
- Arch supports
- Special shoe accessories
- Foot orthotics other than Medically Necessary foot orthotics immediately following foot surgery

Gastric Procedures

Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof.

Genetic Services

Services and supplies for or in connection with nucleic acid level genetic studies or for genetic alteration. This exclusion does not apply to chromosomal analysis.

Growth Hormone

Growth hormone therapy once bone growth is complete.

Hearing Treatment

Routine hearing examinations, cochlear implants, programs, or treatment for hearing loss, including but not limited to hearing aids (internal or external); implantable hearing aids and the surgery and services necessary to implant them.

High Risk Activities

Services and supplies for injuries sustained in:

- Aviation accidents (including accidents occurring in flight or in the course of take-off or landing), unless You are a passenger on a scheduled commercial airline flight; and
- The course of parachuting or hang-gliding.

Mental Health Treatment

Care or treatment of the following:

- Marital or family problems
- Social, occupational, religious, or other social maladjustment
- Conduct disorders
- Chronic situational reactions

Military Service-Related Conditions

Services and supplies for treatment of an Illness or Injury caused by or incurred during service in the armed forces of any state or country.

Obesity or Weight Reduction/Control

Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery

Services and supplies to change the position (augmentation or reduction procedures) of a bone of the upper or lower jaw (orthognathic surgery).

Other Party Liability

Services and supplies for treatment of Illness or Injury for which a third party is responsible, including:

- Any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement
- An automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist coverage, homeowners coverage, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to a Member, whether or not the Member, if eligible, files a claim for benefits under such coverage.

Personal Comfort Items

Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics,

or other nontherapeutic purposes. For example, We do not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room.

Personality Disorder, Learning Disability, etc.

Care or treatment of chronic organic brain syndrome, personality disorder, learning disability, or mental retardation, except to the extent Covered Services are required to diagnose such conditions.

Physical Exercise Programs and Equipment

Physical exercise programs or equipment, including hot tubs, or membership fees at spas, health clubs, or other such facilities whether or not the program, equipment, or membership is recommended by the Enrollee's Provider.

Preparation of Forms/Missed Appointments

Charges for preparing medical reports, itemized bills or claims forms; appointments scheduled and not kept ("missed appointments").

Prescription Drugs And Other Medications

Outpatient prescription drugs and over-the-counter drugs and medications (except as may be provided in the Prescription Drug Rider attached to this Agreement), vitamins, minerals, special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors.

Private Duty Nursing

Private duty nursing or hourly nursing services, including ongoing hourly shift care in the home.

Psychoanalysis/Psychotherapy

Psychoanalysis or psychotherapy credited toward earning a degree or furthering an Enrollee's education or training.

Riot, Rebellion, War and Illegal Acts

Services and supplies for treatment of an Illness or Injury caused by a member's voluntary participation in a riot or war, insurrection, rebellion, armed invasion or aggression, commitment of an illegal act or felony.

Routine Physical Examinations, Tests, Screening Procedures, and Immunizations

Unless specifically described as a benefit under the Agreement, routine physical examinations, including tests, screening procedures, and immunizations when the Enrollee has no symptoms of Illness or Injury (for example, cancer screening tests and general health screening tests). We will, however, cover tetanus or rabies vaccinations administered in connection with an Accidental Injury.

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Self-Help, Self-Care, Training, or Instructional Programs

Self-help, non-medical self-care, training, educational, or instructional programs. Unless specifically described as a benefit, this includes diet and weight monitoring services, instruction programs including those to learn how to self-administer prescriptions or nutrition, and programs that explain how to use Durable Medical Equipment or how to care for a person in the family. This exclusion does not apply to services for training or educating an Enrollee when incidentally provided, without separate charge, in connection with Covered Services.

Services and Supplies for Which No Charge is Made or No Charge is Normally Made

Services and supplies for which an Enrollee is not required to make payment or for charges that in the absence of this Agreement there would be no obligation to pay. This would include but is not limited to:

- Services or supplies for which an Enrollee cannot be held liable because of an agreement between the Provider rendering the service and another third party payor which has already paid for such service or supply; and
- Services for which the Enrollee incurs no charge or has no legal obligation to pay.

Services and Supplies Otherwise Available from a Governmental Agency or Program

Services and supplies to the extent benefits are provided or covered by any governmental agency (for example, a federal hospital or the Veterans Administration), unless reimbursement under the Agreement is otherwise required by law. Also excluded are services covered by programs created by the laws of the United States, any state, or any political subdivision of a state, or which would be so covered except for coverage under this Agreement.

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a member of Your Immediate Family. For purposes of this provision, "Immediate Family" means parents, spouse, children, siblings, half-siblings, in-laws, or any relative by blood or marriage.

Services and Supplies Provided by a School or Halfway House

Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

Services and Supplies Provided Outside Utah

Services and supplies provided outside of Utah that would not have been licensed in Utah, or that may not be legally provided in Utah.

Services and Supplies that are NOT Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury except for preventive care benefits if specifically provided under the Agreement.

Services, Supplies and Drugs NOT yet Approved by the FDA

Services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for other than its FDA-approved purpose.

Sexual Counseling, Treatment, or Surgery

Counseling, treatment (including drugs), or surgery for sexual dysfunction, including but not limited to transsexualism, psychosexual identity disorder, psychosexual disorder or gender dysphoria.

Temporomandibular Joint (TMJ) Dysfunction Treatment

Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction other than surgical correction of the TMJ required as a result of an Accidental Injury.

Tobacco Addiction Treatment

Treatment of tobacco addiction, including supplies for addiction to tobacco, tobacco products, or nicotine substitutes.

Travel and Transportation Expenses

Travel and Transportation expenses other than covered Ambulance Services provided under the Agreement.

Treatment, Procedures, Techniques or Therapies Outside Accepted Health Care Practice

Treatment or prevention of Illness or Injury by means of treatments, procedures, techniques or therapies outside generally accepted health-care practice, as determined by Us.

Vision Care

Services and supplies related to vision care, unless specifically described as a benefit under the Agreement, including but not limited to:

- Routine screening examinations or assessment for refractive error
- The fitting, provision, or replacement of eyeglasses
- Contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery
- Visual therapy, training, and eye exercises
- Vision orthoptics

- Vitamin therapy for vision
- Fundus photography
- Surgical procedures to correct refractive errors/astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded

Visits or Consultations that are not In-Person

Any telephone, internet (or other electronic communication, including tele-medicine) visits or consultations, whether initiated by You or Your Provider.

Eligibility

In general, if you or your spouse is covered (or will be eligible to be covered) by a Regence BCBSU, Regence ValueCare or Regence HealthWise group insurance plan, you are not eligible for coverage under one of our individual health insurance plans.

If you allow your employer to pay the premiums directly (or reimburse you for the premiums) on this policy, the policy will be considered a group policy, and you will not be eligible for coverage under this plan.

All eligible family members must be enrolled unless otherwise approved by Regence BCBSU.

You are eligible to apply if you are a Utah tax-paying resident and at least 16 years but less than 65 years of age.

You may also apply for . . .

- Your spouse who is less than 65 years of age.
- Your unmarried child who is 2 weeks, and has had a 2 week medical examination, to 26 years of age, and who has been dependent on you for more than 50% of his or her total support for the three months preceding the date of application. For a child born or placed for adoption within the three-month period preceding the date of application, the 50% support test shall apply since the child's date of birth or placement for adoption. When applying for your 2 week old child, you must include a copy of his or her 2 week medical examination with the application form.
- A child who is under 18 years of age, and for whom a Subscriber is required by a court order or administrative order to provide health insurance coverage.
- Continue coverage for a child who is a Disabled Dependent due to a Physical or Mental Impairment which started before the child reached age 26. To do so, the Member must provide written notices of intent to continue coverage along with proof of dependent's disability as follows:
 - Within 30 days after the dependent reaches age 26
 - At reasonable times thereafter as Regence BCBSU may consider necessary, but not more often than annually.

- A Member may continue coverage for a child whose 26th birthday precedes his or her Effective Date and who is a Disabled Dependent due to a Physical or Mental Impairment that started before the child reached age 26, if the child also, since reaching age 26, continuously has been covered by health insurance with no break in coverage of more than 63 days. To do so, the Member must provide written notices of intent to continue coverage along with proof of dependent's disability as follows:

- Within 30 days after the dependent reaches age 26; and
- At reasonable times thereafter as Regence BCBSU may consider necessary, but not more often than annually.

A custodial parent (who isn't the Subscriber) or the state Medicaid agency has the right to apply for coverage for certain dependents, a child who is under 18 years of age, and for whom a Subscriber is required by a court order or administrative order to provide health insurance coverage and to submit claims and receive reimbursement when Non-Participating Providers are used.

In certain situations, parents, adoptive parents, and those who have obtained court-appointed legal guardianship who are not eligible for coverage themselves, may apply for coverage for children up to age 16. Underwriting approval is required.

If after enrollment in the Regence BCBSU Individual BlueChoices health-care plans, you have a child born or placed for adoption after your Effective Date, the following provisions apply:

- If you already have Dependent coverage, coverage begins on the date the child is born or placed for adoption, but only if you give Regence BCBSU written notice of the birth or placement for adoption within 30 days after Regence BCBSU sends a denial of a claim for benefits for such new Dependent and you fully pay the required Premiums, if applicable. If written notice of the birth or placement for adoption is not received by Regence BCBSU within 30 days after the denial of a claim for benefits for such new Dependent, coverage begins on the date Regence BCBSU formally accepts your application for coverage of the child.
- If you do not have Dependent coverage, coverage begins on the date the child is born or placed for adoption, but only if you give Regence BCBSU written notice of the birth or the placement for adoption within 30 days after the birth or placement for adoption and you fully pay the required Premiums. If written notice of the birth or placement for adoption is not received by Regence BCBSU within 30 days after the birth or placement for adoption, coverage begins on the date Regence BCBSU formally accepts your application for coverage of the child.

Termination

Coverage will terminate in the event of:

- Failure to pay premiums
- Establishment of residence outside Utah
- Fraud or material misrepresentation
- Loss of dependent eligibility

Your coverage cannot be terminated for health reasons. Regence BCBSU has the right to terminate the Health Care Agreement if Regence BCBSU:

- Eliminates coverage under the Health Care Agreement for all Subscribers (in which case Regence BCBSU shall provide ninety (90) days prior written notice to all Members covered under the Health Care Agreement and shall make available to the Subscriber, without regard to the claims experience or health status of any Enrollee, the option to purchase any other individual policy being offered by Regence BCBSU or an affiliate of Regence BCBSU for which they qualify)
- Elects not to renew all health benefit plans issued to individuals in Utah, in which case, Regence BCBSU shall provide 180 days prior written notice to all members covered under the Health Care Agreement.

Participating Providers

Regence BCBSU has a special arrangement with most physicians, hospitals and other health-care providers in Utah. One of the advantages of this special arrangement is the simple way your claims are handled when you receive services from Participating Providers. When you receive Covered Services from a Participating Provider, present your member card and furnish any additional information required. The Participating Provider will provide to Regence BCBSU the necessary forms and information to process your claim. Regence BCBSU will pay the Participating Provider directly for Covered Services.

Another advantage of this special arrangement with Participating Providers is that when Eligible Medical Expenses (EME) (the amount Participating Providers have agreed to accept as full payment for Covered Services) are less than the amounts actually billed by the Participating Provider, the Participating Provider will accept the amount of Eligible Medical Expenses as payment in full. Your share of Eligible Medical Expenses is the amount you must pay for Deductible, Copayment, and Coinsurance stated in the Health Care Agreement.

Out-of-Area (BlueCard Program)

When you obtain health-care services through the BlueCard Program outside the geographic area Regence BCBSU serves, the amount you pay for Covered Services is usually calculated from the lower of:

- The actual billed charges for your Covered Services, or
- The negotiated price that the host Blue Cross and/or Blue Shield Plan passes on to Regence BCBSU.

Often, this “negotiated price” will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health-care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

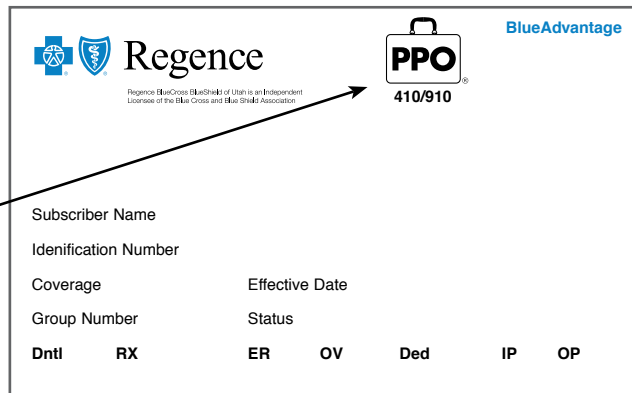
In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive Covered Services in one of those states, the required payment for those services will be calculated using that state’s statutory methods.

Non-Participating Providers

When you receive Covered Services from a Non-Participating Provider, benefit payments will be made directly to you, and you will be responsible for paying the Non-Participating Provider for Covered Services. You cannot assign or transfer the benefits of this plan to a Non-Participating Provider or to any other person or entity. Such an assignment will be null and void. You should note that the charges of a Non-Participating Provider might exceed Eligible Medical Expenses. The Plan does not cover such excess charges and they do not apply toward your Out-of-Pocket Maximum.

For you to receive benefit payments for Covered Services provided by a Non-Participating Provider, you may need to submit your own claim. In that case, obtain an itemized statement from the Non-Participating Provider, attach it to a claim form, and submit it to Regence BCBSU. Be sure to include your name, age, sex, contract (identification) number, and any other information requested by Regence BCBSU. Claim forms can be obtained from our website www.regence.com or by contacting our Member Services Department at (801) 333-2100 or toll-free at 1(800) 624-6519.

NOTE: IF YOU HAVE SELECTED THE REGENCE VALUECARE NETWORK, PROVIDERS WHO PARTICIPATE WITH REGENCE VALUECARE ARE PARTICIPATING PROVIDERS AND PROVIDERS WHO DO NOT PARTICIPATE WITH REGENCE VALUECARE ARE NON-PARTICIPATING PROVIDERS. REGENCE VALUECARE IS A NETWORK ONLY AND IS NOT AN INSURANCE COMPANY.



Indicates Provider Network, may also refer to Regence ValueCare

Indicates Benefit Plan, may also refer to BlueBasic

Member Card

Your member card is issued after you have been accepted into this Health Care Plan. You will receive it when you receive your Health Care Agreement. When you or your enrolled family members require medical or hospital attention, just present your member card. Key information is contained on your card that assists in proper handling of your claim.

Under the \$250, \$500, and \$1,000 Deductible plans, your member card is also your Prescription Drug card. Most pharmacies in Utah accept this card when you order your prescriptions.

Under the \$2,500, \$5,000 and \$7,500 Deductible plans, your member card serves as a discount card for the purchase of Prescription Drugs at Participating Pharmacies.

Changes in Family Status and Address

To change your status as a result of divorce or death, or to change your address, use our Change Form E-27. To change your status as a result of marriage or adding dependents, use our Change Form E-27 and a Health Statement Questionnaire. All family additions must be medically underwritten, except for a newborn or adoptive child, or a child whom you are required by a court or administrative order to provide health insurance coverage as described in the eligibility section. If necessary dependent information is not on Regence BCBSU's membership files, benefits may be delayed or denied for such individuals. A Change Form E-27 can be obtained from our website www.regence.com or by contacting our member services department at (801) 333-2100 or toll-free at 1 (800) 624-6519.

Other Party Liability

If another party is responsible for your illness or injury, the benefits paid under this program may be subject to subrogation. Subrogation means that Regence BCBSU will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that you receive as a recovery from the other party, whether or not you are made whole by the recovery and whether or not the recovery includes any amount for Covered Services.

Coordination of Benefits

When you or your family members are also enrolled in another health plan, payments for Covered Services will be determined by coordinating the benefits of the two programs. Dual coverage will provide the maximum benefits to which you are entitled while preventing payment duplication. The primary health plan pays the full benefits covered under its program, and then the secondary health plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

Appeals Process

A fair and well established multi-level process is available to you to resolve any complaints or grievances regarding a claim denial or other action by Regence BCBSU with internal and external reviews. Refer to the Health Care Agreement for further information.

Application for Membership

After carefully reading this brochure and deciding to apply for coverage, you should complete the enrollment Application and return it to Regence BCBSU. Premiums are determined by the plan selected, health status, the gender and age of the adult insured(s), and the number of children, if any, covered under the policy.

We rely on the information you provide for yourself and your dependents, so the information must be complete and accurate for each person to be enrolled. Acceptance of your application is based upon the health and prior insurance status of you and your family members, if any, and thus:

- Coverage may be accepted at the current rates or
- Certain health conditions may necessitate coverage acceptance at a higher rate level or
- Coverage may be denied for failure to meet our underwriting requirements in accordance with federal/state health care reform regulations.

Policy Effective Date

Review of your completed Application generally takes about ten (10) working days. Your coverage effective date will be assigned on the first of the month after your application has been reviewed and accepted. If there is a delay in accepting your application and the effective date is postponed, you will be notified.

Payment of Premiums

Premiums are payable to Regence BCBSU. If premiums are not fully paid within 30 days after the due date, coverage under the Health Care Agreement is automatically terminated effective with the due date of the unpaid premiums. You will be notified of any increase or decrease in premiums 30 days in advance of the change. Rate adjustments typically occur once each year (currently in July, but subject to change), and apply to all individual and family plans in-force on the effective date of the adjustment, regardless of the date the Agreement was issued.

Regence BCBSU can change your premium or modify your benefits only if it does so for all Subscribers in your class. The amount of your premium is in accordance with the rate schedules in effect at the time of coverage and is based on the plan you have selected, health status, the gender and age of the adult insured(s), and number of children, if any, covered under the policy. You will not receive separate advance notice of premium changes due to your age change.

If you have an agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BCBSU. Incentives may be based on any of several factors, including the size of group business, the products you buy, your agent's volume of business with Regence and the other services your agent provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your agent.

Payment Plan Options

When completing your Application and Health Statement, select one of the following payment options and indicate your choice on the application form.

Monthly SurePay

SurePay allows you to have your premium withdrawn automatically each month from your personal checking or savings account. Payments are made monthly rather than quarterly, making your budgeting process easier. SurePay eliminates postage costs, as well as the time and expense of writing checks.

Monthly Bill

If you choose, you can receive a monthly bill. This method of paying your premium adds an additional \$5 charge per month.

Quarterly Bill

If you choose, you can receive a quarterly billing, mailed to your home address as indicated on your application. When your policy is issued we will make a bill for your first quarterly premium and you will be billed on a quarterly basis thereafter. The enclosed rate table shows monthly premiums. If you choose the quarterly bill, multiply the monthly premium by three. There is no additional charge for the quarterly billing option.

Ten-Day Review Period

You will have ten (10) days after you receive the Regence BCBSU Agreement to review the provisions of the Agreement and to review the benefits, limitations, and exclusions of the plan before acceptance. You may cancel within the 10-day review period and receive a full refund of your premium. There is no provision for premium refund after the 10-day review period. If your premium is refunded, the Regence BCBSU Agreement shall be void from the Effective Date.

Individual BlueChoices Frequently Asked Questions

What is the difference between BlueAdvantage and BlueBasic?

The differences between BlueAdvantage and BlueBasic are among the deductibles, coinsurance levels and office copay amounts. BlueAdvantage is an 80% / 20% coinsurance plan that has both high and low deductibles. The low deductibles offer a \$20 office copayment, while the high deductibles offer coinsurance amounts for the office visit.

BlueBasic is a 70% / 30% coinsurance plan that has both high and low deductibles. The low deductibles offer a \$30 office copayment, while the high deductibles offer coinsurance amounts for the office visit.

What is coinsurance?

Coinsurance is a way for members to share the cost of health care with us to keep premiums affordable. An example is when we pay 70% of health-care costs, the enrollee will pay the remaining 30%.

What are the advantages of using an agent and how much does it cost?

Knowledgeable health insurance agents can explain the differences between the various plans that are available and can help you determine which ones might be the most beneficial for you. The cost to you is the same whether you apply with the help of an agent or apply by yourself.

Can I cover my entire family?

Yes. All eligible family members must apply for coverage. Eligible dependents include your spouse and children 2 weeks to age 26 who are primarily dependent on you for support, including children for whom you are required by a court or administrative order to provide health insurance coverage. Children who are older than 26 and do not fall under our definition of “dependent” may apply for their own coverage.

Can I receive health care while traveling?

The BlueCard program provides in-network coverage in every state. It enables members to obtain health-care services while traveling or living in another plan’s service area to receive the benefits of the Blue Cross and Blue Shield plan listed on their insurance card and to access the local plan’s provider networks and savings. For assistance call BlueCard at 1 (800) 810-BLUE (2589).

What is a pre-existing condition and how long is the pre-existing condition waiting period?

A pre-existing condition is one for which medical advice was given, or for which a health-care provider recommended or provided treatment within six months prior to the date we received your completed application and health questionnaire. Regence BCBSU plans contain a 12-month waiting period for pre-existing conditions. This waiting period excludes coverage for a 12-month period for you and your dependents’ pre-existing conditions.

Do Regence BlueCross BlueShield of Utah Individual plans cover maternity?

Yes. Our BlueChoices plans include a \$5,000 copayment for maternity. After the \$5,000 co payment has been met, Regence BCBSU pays 100% of all eligible expenses.

What if I need emergency care?

Any time you believe it is an emergency, you should go to an emergency room for your care. An emergency is generally defined as follows: If a person who possesses an average knowledge of health and medicine and is acting reasonably and would consider the situation to be an emergency, then your emergency care will be covered by Regence BCBSU. If you are admitted as an inpatient and the hospital is not an in-network provider, please call Regence BCBSU within 24 hours of the emergency or as soon as possible.

What plans cover prescription drugs?

All BlueChoices plans provide prescription coverage. The higher-deductible plans (\$2,500, \$5,000 and \$7,500) cover prescriptions at 80% or 70% after the medical deductible has been met. All of the lower-deductible plans (\$250, \$500 and \$1,000) have a prescription card. The lower deductible BlueBasic plans have a separate annual prescription

deductible of \$200. After this deductible is met, generic prescriptions are covered with a \$10 copayment. The lower deductible BlueAdvantage plans have no prescription deductible, and generics are covered with a \$5 copayment. The lower deductible policies of both plans cover preferred drugs and diabetic supplies at 75%, and non-preferred drugs at 50%.

What individual and family plans cover preventive care?

All of our individual and family plans cover preventive care. However, because we have several different plans, some with office copays and some have different deductible and coinsurance amounts, the amount you will have to pay out-of-pocket differs from plan to plan.

Will my rates change?

The rates for individual BlueChoices plans are typically subject to change once each year, currently in July, and apply to all individual and family plans regardless of the date your coverage began. You may also experience a rate change as you get older and move from one age category to another. Additionally, there may be other situations which cause a rate change. Please see the Health Care Agreement for additional details on rate changes.

What is the Health Insurance Portability & Accountability ACT (HIPAA) and what does it mean to me?

The Health Insurance Portability and Accountability Act (HIPAA) went into effect on July 1, 1997. It is one of the broadest pieces of Federal regulation affecting the health insurance industry across the United States. It has many different aspects ranging from the protection of an insured person’s insurability, to the manner in which medical information is gathered and transmitted between doctors, hospitals and insurance companies.

Why should I choose Regence BlueCross BlueShield of Utah?

There are many reasons including stability, longevity, experience and knowledge. Regence BCBSU has been providing health insurance coverage for Utahns for more than 60 years. As a long-time enrollee of the Blue Cross and Blue Shield Association, our name and our logo are recognized worldwide. Your Regence BCBSU member card will open doors to physicians and hospitals wherever you go. Our relationship with other Blue Cross and Blue Shield plans throughout the world enables us to provide you with the best care possible at the most competitive prices.

Regence HSA Healthplan Outline of Coverage

General Information

This outline of coverage is a benefit description of the important features of your Health Care Agreement. The outline of coverage is not the insurance contract and only the actual provisions of the Health Care Agreement will control. After you are accepted, a Health Care Agreement and member card will be mailed to you. Please read your Health Care Agreement carefully. The Health Care Agreement itself sets forth in detail the rights and obligations of both you and Regence BCBSU. It is, therefore, important that you READ YOUR HEALTH CARE AGREEMENT CAREFULLY.

Regence HSA Healthplan is designed to provide coverage for major hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any Deductibles, Coinsurance, or other limitations which may be set forth in the Health Care Agreement.

In addition, the Regence HSA Healthplan can be paired with an HSA account from the financial institution of your choice as a tax-free savings vehicle to fund qualified medical expenses.

This is Not a Medicare Supplement Contract

If you or a family member become eligible for Medicare, you should review the Medicare Supplement Buyer's Guide available from Regence BCBSU. If you choose to continue coverage under the Health Care Agreement and Medicare, the benefits of the Health Care Agreement shall be reduced by any amounts paid by Medicare.

Your Rights to Waive PEC Waiting Periods

Federal and state health insurance regulations provide portability (reduction or elimination of the pre-existing condition (PEC) waiting period because of prior coverage) for certain individuals and families who meet the established guidelines. Refer to Special Notices on page 27 of this booklet. Contact your insurance agent or Regence BCBSU for more information about these regulations and how they may affect your rights to receive credit toward your PEC waiting period.

What is Covered

Benefits are available for these services and supplies when Medically Necessary.

Inpatient and Outpatient Hospital/Skilled Nursing Facility

- Semi-private room accommodations
- Inpatient Rehabilitation (limited to \$4,000 per Enrollee per Calendar Year)
- Ancillary services and supplies

- Emergency room services
- X-ray and laboratory services

Home Health Care/Home Infusion Therapy Services

- Home Health Care services provided in the Enrollee's home (limited to 130 visits per Enrollee per Calendar Year)
- Home Infusion Therapy services provided in the Enrollee's home
- Other services and supplies

Physician Services

- Surgical services
- Assistant surgeon services
- Anesthesia services
- Inpatient medical services
- Outpatient medical services
- Diagnostic services
- Chemotherapy
- Radiation therapy
- Outpatient rehabilitation and chiropractic services (physical, speech, and occupational therapies and chiropractic care limited to \$2,000 per Enrollee per Calendar Year)
- Consultations
- Preventive services for adults and children age 6 and over and well-baby care for children under age 6
- Dental services for Accidental Injury
- Skilled nursing services
- Dialysis services
- Mental Health Condition (including drug/alcohol use/abuse) services (limited to \$1,500 per Enrollee per Calendar Year)

Prescription Drugs

- Outpatient Prescription Drugs are covered at a Coinsurance level after the medical Deductible per Calendar Year has been met. Your member card serves as a discount card at Participating Pharmacies.
- Growth Hormones (limited to \$20,000 per Enrollee per Calendar Year)

Other Services

- Durable Medical Equipment (limited to \$2,500 per Enrollee per Calendar Year)
- Medical/surgical supplies
- Ambulance services

Diabetic Supplies and Educational Benefits

Diabetic supplies (including needles, syringes, test strips, lancets, and other disposable diabetic supplies) are covered under a Discount Prescription Drug Program issued in conjunction with the basic policy, if applicable, or under the basic policy benefit for Durable Medical Equipment and supplies. Diabetic education received through an accredited or certified diabetic education program is also covered.

Transplants (Limited)

Coverage is available for kidney, cornea, heart, heart/lung, lung, liver, and pancreas transplants, and bone marrow transplants for certain conditions (see the Health Care Agreement for details). Limited to \$250,000 per Enrollee Lifetime.

MAT/HSCS

Coverage is available for Myeloablative Therapy (MAT) With Hematopoietic Stem Cell Support (HSCS) For Malignancies. Specific criteria must be met for coverage to be provided. Prenotification is required. (Included in the \$250,000 per Enrollee Lifetime Transplant Maximum.)

Preventive Care Services

- Professional Exams
 - Coverage is available for adult and child professional exams including routine diagnostic tests, such as lab and x-rays
- Screening Procedures
 - Pap smear; prostate specific antigen (PSA) test; mammography screening; test of the stool for occult blood; bone density scan; sigmoidoscopy; and colonoscopy.
- Immunizations
 - Routine immunizations for childhood diseases
 - Adult immunizations - annual influenza; pneumovax; hepatitis B; hepatitis A; rubella; diphtheria; tetanus toxoid; varicella; and measles and mumps.

Limitations

During the 12-month limitation period following the Enrollee's application for coverage, NO BENEFITS will be provided for:

- Pre-existing conditions which are physical or mental conditions (including but not limited to pregnancy), for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to the Effective date
- Sterilization (e.g., vasectomy, tubal ligation)

We will reduce the duration of the 12 month waiting period by the amount of your combined periods of Creditable Coverage if you have been covered by Qualifying Coverage, provided there is no break in coverage greater than 63 days immediately preceding your application for coverage under this Agreement. Coverage may be concurrent.

Qualifying Coverage means only the following: group coverage (including self-funded plans); individual coverage (including student health plans); S-CHIP; Medicaid; Medicare; CHAMPUS/Tricare; Indian Health Service or tribal organization coverage; state high risk pool coverage; and public health plans (including foreign government and US government plans).

Coverage for Job or Work-Related Claims or Illnesses

Normally, job or work-related claims that are paid under any workers' compensation or employer liability insurance are excluded from coverage under the Health Care Agreement. However, if you are not required by law to be covered under workers compensation insurance, coverage may be available for the cost of care and treatment related to such a claim, in accordance with the terms, conditions, limitations, and exclusions of the Health Care Agreement. Coverage under the Health Care Agreement will be evaluated at the time a claim for such care and treatment is received by Regence BCBSU and may require additional information from you to determine your entitlement to coverage under the Health Care Agreement.

Exclusions

No benefits will be provided for any of the following conditions, treatments, services, supplies, or accommodations, or for any direct complications or consequences thereof.

Alternative Care

The following types of alternative care:

- Acupuncture and acupressure
- Holistic and homeopathic treatment
- Massage or massage therapy
- Naturopathy
- Faith healing
- Milieu therapy
- Hypnosis
- Sensitivity training
- Behavior modification
- Biofeedback
- Electrohypnosis, electrosleep therapy, or electronarcosis
- Ecological or environmental medicine
- Other therapies: scream therapy; psychic surgery, channeling, sensory deprivation; rolfing; thermography; music, art, dance, or recreation therapy; crystal therapy; and hypertherapy (therapeutically induced fever) for the treatment of cancer.

Appliances or Restorations Necessary to Increase Vertical Dimension or Restore Occlusion

Automobile Personal Injury Protection Coverage

Services and supplies for the treatment of an Injury or Illness that are the responsibility of any automobile personal injury protection (“PIP”) coverage, including:

- Coverage up to the minimum amount required by state or federal law, regardless of whether or not such coverage is in force
- Any amount of coverage carried in excess of the minimum amount required by state or federal law, regardless of whether or not the Enrollee files a claim for benefits under such coverage

Benefits Not Stated

Services and supplies provided for which there is no stated benefit under the Agreement. When a non-covered service or supply is performed or received at the same time as a Covered Service, then only the portion of charges relating to the Covered Service will be considered eligible for payment under this Agreement.

Birth Control/Infertility

Services and supplies in connection with the following:

- Non-prescription contraceptives
- Reversal of voluntary surgically performed sterilization or subsequent re-sterilization
- Artificial insemination or in vitro fertilization
- Infertility, except to the extent Covered Services are required to diagnose such condition
- Fertility drugs and medications

Charges That Exceed Eligible Medical Expenses

Any charge for services and supplies that exceed Eligible Medical Expenses.

Cosmetic/Reconstructive Services and Supplies

Cosmetic and/or Reconstructive services and supplies (including direct complications or consequences thereof), including blepharoplasty and otoplasty, except in the case of surgery that is:

- Performed to restore a physical bodily function
- Related to an Accidental Injury
- Related to breast Reconstruction following a Medically Necessary mastectomy to the extent required by law

Cosmetic means services or supplies that are applied to normal structures of the body primarily for the purpose of improving or changing appearance.

Reconstructive means services, procedures, and surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to restore function, but may also be done to approximate a normal appearance.

For the purposes of this Agreement, psychological factors (for example, poor self-image, difficult social or peer relations) are not relevant and are not considered a physical bodily function.

Counseling

Charges for counseling an Enrollee, including the following:

- Marital counseling
- Family counseling
- Educational, social, occupational, or religious counseling
- Counseling in the absence of Illness or Injury
- Counseling with a patient’s family, friend(s), employer, school counselor, or school teacher

This exclusion does not apply to services for counseling an Enrollee when incidentally provided, without separate charge, in connection with Covered Services.

Court-Ordered or Court-Related Services/ Services in Connection with Legal Proceedings

Services, supplies, examinations, reports, or appearances in connection with legal proceedings or court ordered or court-related services.

Custodial, Domiciliary and Convalescent Care

Custodial Care, domiciliary care, convalescent care (other than extended care), rest cures, and services provided for or in connection with institutional care which is for the primary purpose of controlling or changing the Enrollee’s environment.

Custodial Care means care that mainly provides room and board (meals), or if it is for a physically or mentally disabled person who is not receiving care specifically to reduce the disability so that the person can live outside a medical care facility or nursing home. No matter where the person lives, care is considered Custodial Care if it is non-skilled nursing care, training in personal hygiene, other forms of self-care, supervisory care by a Provider, or care provided by a health-care facility licensed by the State of Utah as an assisted living facility, hospice, residential health-care facility, or small health-care facility, or that is similarly licensed by the state in which it is located.

Dental Services

Dental Services, unless the Agreement specifically covers them.

Erectile Dysfunction

Services and supplies for or in connection with erectile dysfunction, regardless of its origin.

Expenses Incurred Before Coverage Begins or After Coverage Ends

Services and supplies incurred before enrollment under the Agreement or after termination under the Agreement.

Experimental or Investigational Services

Experimental or investigational treatments or procedures; and services, supplies, and accommodations provided in connection with experimental or investigational treatments or procedures. A treatment or procedure will be considered experimental or investigational if reasonable and substantial scientific evaluation has not been completed, effectiveness has not been established, or the procedure or treatment has not been accepted and generally used by the medical Provider community for a period of 5 years. Our Medical Director will determine whether a treatment or procedure is experimental or investigational. The absence of any alternative treatment or procedure or any effective non-experimental or non-investigational treatment or procedure for an Illness or Injury shall not make or be deemed to make an experimental or investigational treatment or procedure a Covered Service.

Fees, Taxes, Interest, etc.

Charges for shipping and handling, postage, interest or finance charges that a Provider might bill. We also do not cover excise, sales, or other taxes; surcharges; tariffs; duties; assessments; or other similar charges whether made by federal, state, or local government, or by another entity, unless required by law.

Foot Care

Foot care, including but not limited to:

- Treatment of corns and calluses
- Trimming of nails (we do cover surgery for ingrown toenails)
- Foot impression casting including x-rays
- Nonsurgical treatment of bunions, flat feet, fallen arches, weak feet, chronic foot strain, or other symptomatic complaints of the foot
- Arch supports
- Special shoe accessories
- Foot orthotics other than Medically Necessary foot orthotics immediately following foot surgery

Gastric Procedures

Services and supplies for or in connection with gastric or intestinal bypass, gastric stapling, or other similar surgical procedure, or for or in connection with reversal or revision of such procedures, or any direct complications or consequences thereof.

Genetic Services

Services and supplies for or in connection with nucleic acid level genetic studies or for genetic alteration. This exclusion does not apply to chromosomal analysis.

Growth Hormone

Growth hormone therapy once bone growth is complete.

Hearing Treatment

Routine hearing examinations, cochlear implants, programs, or treatment for hearing loss, including but not limited to hearing aids (internal or external); implantable hearing aids and the surgery and services necessary to implant them.

High Risk Activities

Services and supplies for injuries sustained in:

- Aviation accidents (including accidents occurring in flight or in the course of take-off or landing), unless You are a passenger on a scheduled commercial airline flight
- The course of parachuting or hang-gliding

Maternity Care

Mental Health Treatment

Care or treatment of the following:

- Marital or family problems
- Social, occupational, religious, or other social maladjustment
- Conduct disorders
- Chronic situational reactions

Military Service-Related Conditions

Services and supplies for treatment of an Illness or Injury caused by or incurred during service in the armed forces of any state or country.

Obesity or Weight Reduction/Control

Medical or surgical treatment (including reversals), programs, or supplies that are intended to result in weight reduction, regardless of diagnosis or psychological conditions.

Orthognathic Surgery

Services and supplies to change the position (augmentation or reduction procedures) of a bone of the upper or lower jaw (orthognathic surgery).

Other Party Liability

Services and supplies for treatment of Illness or Injury for which a third party is responsible, including:

- Any work related Injury or Illness, including any claims that are resolved pursuant to a disputed claim settlement
- An automobile medical, personal injury protection ("PIP"), automobile no-fault, underinsured or uninsured motorist

coverage, homeowners coverage, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to or makes benefits available to a Member, whether or not the Member, if eligible, files a claim for benefits under such coverage.

Personal Comfort Items

Items that are primarily used for personal comfort or convenience, contentment, personal hygiene, aesthetics, or other nontherapeutic purposes. For example, We do not cover telephones, television, and guest meals while in a facility if they are charged separately from the cost of the room.

Personality Disorder, Learning Disability, etc.

Care or treatment of chronic organic brain syndrome, personality disorder, learning disability, or mental retardation, except to the extent Covered Services are required to diagnose such conditions.

Physical Exercise Programs and Equipment

Physical exercise programs or equipment, including hot tubs, or membership fees at spas, health clubs, or other such facilities whether or not the program, equipment, or membership is recommended by the Enrollee's Provider.

Preparation of Forms/Missed Appointments

Charges for preparing medical reports, itemized bills or claims forms; appointments scheduled and not kept ("missed appointments").

Prescription Drugs And Other Medications

Outpatient prescription drugs and over-the-counter drugs and medications (except as may be provided in the Prescription Drug Rider attached to this Agreement), vitamins, minerals, special formulas, food supplements, or special diets, except as provided by a Hospital or Skilled Nursing Facility during a confinement for which benefits are available and as required for inborn metabolic errors.

Private Duty Nursing

Private duty nursing or hourly nursing services, including ongoing hourly shift care in the home.

Psychoanalysis/Psychotherapy

Psychoanalysis or psychotherapy credited toward earning a degree or furthering an Enrollee's education or training.

Riot, Rebellion, War and Illegal Acts

Services and supplies for treatment of an Illness or Injury caused by a member's voluntary participation in a riot or war, insurrection, rebellion, armed invasion or aggression, commitment of an illegal act or felony.

Routine Physical Examinations, Tests, Screening Procedures, and Immunizations

Unless specifically described as a benefit under the Agreement, routine physical examinations, including tests, screening procedures, and immunizations when the Enrollee has no symptoms of Illness or Injury (for example, cancer screening tests and general health screening tests). We will, however, cover tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Self-Help, Self-Care, Training, or Instructional Programs

Self-help, non-medical self-care, training, educational, or instructional programs. Unless specifically described as a benefit, this includes diet and weight monitoring services, instruction programs including those to learn how to self-administer prescriptions or nutrition, and programs that explain how to use Durable Medical Equipment or how to care for a person in the family. This exclusion does not apply to services for training or educating an Enrollee when incidentally provided, without separate charge, in connection with Covered Services.

Services and Supplies for Which No Charge is Made or No Charge is Normally Made

Services and supplies for which an Enrollee is not required to make payment or for charges that in the absence of this Agreement there would be no obligation to pay. This would include but is not limited to:

- Services or supplies for which an Enrollee cannot be held liable because of an agreement between the Provider rendering the service and another third party payor which has already paid for such service or supply; and
- Services for which the Enrollee incurs no charge or has no legal obligation to pay.

Services and Supplies Otherwise Available from a Governmental Agency or Program

Services and supplies to the extent benefits are provided or covered by any governmental agency (for example, a federal hospital or the Veterans Administration), unless reimbursement under the Agreement is otherwise required by law. Also excluded are services covered by programs created by the laws of the United States, any state, or any political subdivision of a state, or which would be so covered except for coverage under this Agreement.

Services and Supplies Provided by a Member of Your Family

Services and supplies provided to You by a member of Your Immediate Family. For purposes of this provision, "Immediate Family" means parents, spouse, children, siblings, half-siblings, or in-laws, or any relative by blood or marriage.

Services and Supplies Provided by a School or Halfway House

Services and supplies provided by any public or private school or halfway house, or by their employees and services provided solely to satisfy institutional requirements.

Services and Supplies Provided Outside of Utah

Services and supplies provided outside of Utah that would not have been licensed in Utah, or that may not be legally provided in Utah.

Services and Supplies that are NOT Medically Necessary

Services and supplies that are not Medically Necessary for the treatment of an Illness or Injury except for preventive care benefits specifically provided under the Agreement.

Services, Supplies and Drugs NOT Yet Approved by the FDA

Services, supplies or drugs which have not yet been approved by the United States Food and Drug Administration (FDA) or which are used for other than its FDA-approved purpose.

Sexual Counseling, Treatment, or Surgery

Counseling, treatment (including drugs), or surgery for sexual dysfunction, including but not limited to transsexualism, psychosexual identity disorder, psychosexual disorder or gender dysphoria.

Temporomandibular Joint (TMJ) Dysfunction Treatment

Services and supplies provided in connection with temporomandibular joint (TMJ) dysfunction other than surgical correction of the TMJ required as a result of an Accidental Injury.

Tobacco Addiction Treatment

Treatment of tobacco addiction, including supplies for addiction to tobacco, tobacco products, or nicotine substitutes.

Travel and Transportation Expenses

Travel and Transportation expenses other than covered Ambulance Services provided under the Agreement.

Treatment, Procedures, Techniques or Therapies Outside Accepted Health Care Practice

Treatment or prevention of Illness or Injury by means of treatments, procedures, techniques or therapies outside generally accepted health-care practice, as determined by Us.

Vision Care

Services and supplies related to vision care, unless specifically described as a benefit under the Agreement, including but not limited to:

- Routine screening examinations or assessment for refractive error;
- The fitting, provision, or replacement of eyeglasses
- Contact lenses, including contact lens checks, except for the first intraocular lenses following cataract surgery
- Visual therapy, training, and eye exercises
- Vision orthoptics
- Vitamin therapy for vision;
- Fundus photography; and
- Surgical procedures to correct refractive errors/ astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye are excluded.

Visits or Consultations that are not In-Person

Any telephone, internet (or other electronic communication, including tele-medicine) visits or consultations, whether initiated by You or Your Provider.

Eligibility

In general, if you or your spouse is covered (or will be eligible to be covered) by a Regence BCBSU, Regence ValueCare or Regence HealthWise group insurance plan, you are not eligible for coverage under one of our individual health insurance plans.

If you allow your employer to pay the premiums directly (or reimburse you for the premiums) on this policy, the policy will be considered a group policy, and you will not be eligible for coverage under this plan.

All eligible family members must be enrolled unless otherwise approved by Regence BCBSU.

You are eligible to apply if you are a Utah tax-paying resident and at least 16 years but less than 65 years of age.

You may also apply for . . .

- Your spouse who is less than 65 years of age.
- Your unmarried child who is 2 weeks, and has had a 2 week medical examination, to 26 years of age, and who has been dependent on you for more than 50% of his or her total support for the three months preceding the date of application. For a child born or placed for adoption within the three-month period preceding the date of application, the 50% support test shall apply since the child's date of birth or placement for adoption. When applying for your 2 week old child, you must include a copy of his or her 2 week medical examination with the application form.

- A child who is under 18 years of age, and for whom a Subscriber is required by a court order or administrative order to provide health insurance coverage.
- Continue coverage for a child who is a Disabled Dependent due to a Physical or Mental Impairment which started before the child reached age 26. To do so, the Member must provide written notices of intent to continue coverage along with proof of dependent's disability as follows:
 - within 30 days after the dependent reaches age 26; and
 - at reasonable times thereafter as Regence BCBSU may consider necessary, but not more often than annually.
- A Member may continue coverage for a child whose 26th birthday precedes his or her Effective Date and who is a Disabled Dependent due to a Physical or Mental Impairment that started before the child reached age 26, if the child also, since reaching age 26, continuously has been covered by health insurance with no break in coverage of more than 63 days. To do so, the Member must provide written notices of intent to continue coverage along with proof of dependent's disability as follows:
 - within 30 days after the dependent reaches age 26; and
 - at reasonable times thereafter as Regence BCBSU may consider necessary, but not more often than annually.

A custodial parent (who isn't the Subscriber) or the state Medicaid agency has the right to apply for coverage for certain dependents, a child who is under 18 years of age, and for whom a Subscriber is required by a court order or administrative order to provide health insurance coverage and to submit claims and receive reimbursement when Non-Participating Providers are used.

In certain situations, parents, adoptive parents, and those who have obtained court-appointed legal guardianship who are not eligible for coverage themselves, may apply for coverage for children up to age 16. Underwriting approval is required.

If after enrollment in the Regence BCBSU Individual BlueChoices health-care plans, you have a child born or placed for adoption after your Effective Date, the following provisions apply:

- If you already have Dependent coverage, coverage begins on the date the child is born or placed for adoption, but only if you give Regence BCBSU written notice of the birth or placement for adoption within 30 days after Regence BCBSU sends a denial of a claim for benefits for such new Dependent and you fully pay the required Premiums, if applicable. If written notice of the birth or placement for adoption is not received by Regence BCBSU within 30 days after the denial of a claim for benefits for such new Dependent, coverage begins on the date Regence BCBSU formally accepts your application for coverage of the child.

- If you do not have Dependent coverage, coverage begins on the date the child is born or placed for adoption, but only if you give Regence BCBSU written notice of the birth or the placement for adoption within 30 days after the birth or placement for adoption and you fully pay the required Premiums. If written notice of the birth or placement for adoption is not received by Regence BCBSU within 30 days after the birth or placement for adoption, coverage begins on the date Regence BCBSU formally accepts your application for coverage of the child.

Termination

Coverage will terminate in the event of:

- Failure to pay premiums,
- Establishment of residence outside Utah,
- Fraud or material misrepresentation, or
- Loss of dependent eligibility.

Your coverage cannot be terminated for health reasons. Regence BCBSU has the right to terminate the Health Care Agreement if Regence BCBSU:

- Eliminates coverage under the Health Care Agreement for all Subscribers (in which case Regence BCBSU shall provide 90 days prior written notice to all Enrollee's covered under the Health Care Agreement and shall make available to the Subscriber, without regard to the claims experience or health status of any Member, the option to purchase any other individual policy being offered by Regence BCBSU or an affiliate of Regence BCBSU for which they qualify), or
- Elects not to renew all health benefit plans issued to individuals in Utah, in which case, Regence BCBSU shall provide 180 days prior written notice to all members covered under the Health Care Agreement.

Participating Providers

Regence BCBSU has a special arrangement with most physicians, hospitals and other health-care providers in Utah. One of the advantages of this special arrangement is the simple way your claims are handled when you receive services from Participating Providers. When you receive Covered Services from a Participating Provider, present your member card and furnish any additional information required. The Participating Provider will provide to Regence BCBSU the necessary forms and information to process your claim. Regence BCBSU will pay the Participating Provider directly for Covered Services.

Another advantage of this special arrangement with Participating Providers is that when Eligible Medical Expenses (EME) (the amount Participating Providers have agreed to accept as full payment for Covered Services) are less than the amounts actually billed by the Participating Provider, the Participating Provider will accept the amount of Eligible Medical Expenses as payment in full. Your share of Eligible Medical Expenses is the amount you must pay for Deductible and Coinsurance stated in the Health Care Agreement.

Out-of-Area (BlueCard Program)

When you obtain health-care services through the BlueCard Program outside the geographic area Regence BCBSU serves, the amount you pay for Covered Services is usually calculated from the lower of:

- The actual billed charges for your Covered Services, or
- The negotiated price that the host Blue Cross and/or Blue Shield Plan passes on to Regence BCBSU.

Often, this “negotiated price” will consist of a simple discount. But sometimes it is an estimated final price that factors in expected settlements or other non-claims transactions with your health-care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects average expected savings. The estimated or average price may be prospectively adjusted to correct for over- or underestimation of past prices.

In addition, laws in a small number of states require Blue Cross and/or Blue Shield Plans to use a basis for calculating your payment for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When you receive Covered Services in one of those states, the required payment for those services will be calculated using that state’s statutory methods.

Non-Participating Providers

When you receive Covered Services from a Non-Participating Provider, benefit payments will be made directly to you, and you will be responsible for paying the Non-Participating Provider for Covered Services. You cannot assign or transfer the benefits of this plan to a Non-Participating Provider or to any other person or entity. Such an assignment will be null and void. You should note that the charges of a Non-Participating Provider might exceed Eligible Medical Expenses. The Plan does not cover such excess charges and they do not apply toward your Out-of-Pocket Maximum.

For you to receive benefit payments for Covered Services provided by a Non-Participating Provider, you may need to submit your own claim. In that case, obtain an itemized statement from the Non-Participating Provider, attach it to a claim form, and submit it to

Regence BCBSU. Be sure to include your name, age, sex, contract (identification) number, and any other information requested by Regence BCBSU. Claim forms can be obtained from our website www.regence.com or by contacting our member services department at (801) 333-2100 or toll-free at 1 (800) 624-6519.

NOTE: IF YOU HAVE SELECTED THE REGENE VALUECARE NETWORK, PROVIDERS WHO PARTICIPATE WITH REGENE VALUECARE ARE PARTICIPATING PROVIDERS AND PROVIDERS WHO DO NOT PARTICIPATE WITH REGENE VALUECARE ARE NONPARTICIPATING PROVIDERS. REGENE VALUECARE IS A NETWORK ONLY AND IS NOT AN INSURANCE COMPANY.

Member Card

Your member card is issued after you have been accepted into this Health Care Plan. You will receive it when you receive your Health Care Agreement. When you or your enrolled family members require medical or hospital attention, just present your member card. Key information is contained on your card that assists in proper handling of your claim.

Your member card serves as a discount card for the purchase of Prescription Drugs at Participating Pharmacies.

Changes in Family Status and Address

To change your status as a result of divorce or death, or to change your address, use our Change Form E-27. To change your status as a result of marriage or adding dependents, use our Change Form E-27 and a Health Statement Questionnaire. All family additions must be medically underwritten, except for a newborn or adoptive child, or a child whom you are required by a court or administrative order to provide health insurance coverage as described in the eligibility section. If necessary dependent information is not on Regence BCBSU’s membership files, benefits may be delayed or denied for such individuals. A Change Form E-27 can be obtained from our website www.regence.com or by contacting our member services department at (801) 333-2100 or toll-free at 1 (800) 624-6519.

The diagram shows a member card layout with the following elements:

- Top Left:** Regence logo with text: "Regence BCBSU of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association."
- Top Right:** "HSA Healthplan" label.
- Center:** "PPO" logo with "410/910" below it.
- Bottom Section:** A table of fields:

Subscriber Name		Effective Date				
Identification Number		Status				
Dntl	RX	ER	OV	Ded	IP	OP

Callouts:

- An arrow points from the text "Indicates Provider Network." to the Regence logo.
- An arrow points from the text "Indicates the Regence HSA Healthplan." to the "HSA Healthplan" label.

Other Party Liability

If another party is responsible for your illness or injury, the benefits paid under this program may be subject to subrogation. Subrogation means that Regence BCBSU will recover the amounts it has paid in benefits out of the proceeds of any settlement or judgment that you receive as a recovery from the other party, whether or not you are made whole by the recovery and whether or not the recovery includes any amount for Covered Services.

Coordination of Benefits

When you or your family members are also enrolled in another health plan, payments for Covered Services will be determined by coordinating the benefits of the two programs. Dual coverage will provide the maximum benefits to which you are entitled while preventing payment duplication. The primary health plan pays the full benefits covered under its program, and then the secondary health plan may reduce its benefits. In no event will payment be made in excess of expenses incurred.

It is important to note that if you have more than one health plan, you may not be eligible for the features of a Health Savings Account (HSA) that you may have in conjunction with this Regence HSA Healthplan.

Appeals Process

A fair and well established multi-level process is available to you to resolve any complaints or grievances regarding a claim denial or other action by Regence BCBSU with internal and external reviews. Refer to the Health Care Agreement for further information.

Application for Membership

After carefully reading this brochure and deciding to apply for coverage, you should complete the enrollment Application and return it to Regence BCBSU. Premiums are determined by the plan selected, health status, the gender and age of the adult insured(s), and the number of children, if any, covered under the policy.

We rely on the information you provide for yourself and your dependents, so the information must be complete and accurate for each person to be enrolled. Acceptance of your application is based upon the health and prior insurance status of you and your family members, if any, and thus:

- Coverage may be accepted at the current rates or
- Certain health conditions may necessitate coverage acceptance at a higher rate level or
- Coverage may be denied for failure to meet our underwriting requirements in accordance with federal/state health care reform regulations.

Policy Effective Date

Review of your completed Application generally takes about ten (10) working days. Your coverage effective date will be assigned on the first of the month after your application has been reviewed and accepted. If there is a delay in accepting your application and the effective date is postponed, you will be notified.

Payment of Premiums

Premiums are payable to Regence BCBSU. If premiums are not fully paid within 30 days after the due date, coverage under the Health Care Agreement is automatically terminated effective with the due date of the unpaid premiums. You will be notified of any increase or decrease in premiums 30 days in advance of the change. Rate adjustments typically occur once each year (currently in July, but subject to change), and apply to all individual and family plans in-force on the effective date of the adjustment, regardless of the date the Agreement was issued.

Regence BCBSU can change your premium or modify your benefits only if it does so for all Subscribers in your class. The amount of your premium is in accordance with the rate schedules in effect at the time of coverage and is based on the plan you have selected, health status, the gender and age of the adult insured(s), and number of children, if any, covered under the policy. You will not receive separate advance notice of premium changes due to your age change.

If you have a broker or agent they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

Payment Plan Options

When completing your Application and Health Statement, select one of the following payment options and indicate your choice on the application form.

Monthly SurePay

SurePay allows you to have your premium withdrawn automatically each month from your personal checking or savings account. Payments are made monthly rather than quarterly, making your budgeting process easier. SurePay eliminates postage costs, as well as the time and expense of writing checks.

Monthly Bill

If you choose, you can receive a monthly bill. This method of paying your premium adds an additional \$5 charge per month.

Quarterly Bill

If you choose, you can receive a quarterly billing, mailed to your home address as indicated on your application. When your policy is issued we will make a bill for your first quarterly premium and you will be billed on a quarterly basis thereafter. The enclosed rate table shows monthly premiums. If you choose the quarterly bill, multiply the monthly premium by three (there is no additional charge for the quarterly billing option).

Ten-Day Review Period

You will have ten (10) days after you receive the Regence BCBSU Agreement to review the provisions of the Agreement and to review the benefits, limitations, and exclusions of the plan before acceptance. You may cancel within the 10-day review period and receive a full refund of your premium. There is no provision for premium refund after the 10-day review period. If your premium is refunded, the Regence BCBSU Agreement shall be void from the Effective Date.

Top HSA FAQs

What is a health savings account?

A health savings account (HSA) is a tax-sheltered savings account, which must be paired with a qualified high deductible health plan (HDHP). Regence provides your HDHP coverage, while the financial institution of your choice administers your HSA. An HSA allows you to set aside tax-deductible, interest-earning funds to help cover your HDHP deductible, coinsurance, and other qualified medical expenses. Any unused funds roll over from year to year, and can later be used for retirement.

What is a “high deductible” health plan?

In order to open and contribute to an HSA, you must be enrolled in a qualified high deductible health plan (HDHP). To qualify as an HDHP for 2008, a plan must have a minimum deductible of \$1,100 (self-only coverage) or \$2,200 (family coverage). The annual out-of-pocket maximum, including deductibles and coinsurance, cannot exceed \$5,600 (self-only coverage) or \$11,200 (family coverage). Finally, all health care benefits covered under the plan, with the exception of preventive care, must be subject to the deductible.

How does the HDHP deductible work?

If you enroll in self-only coverage, you must meet your deductible before any benefits (except preventive care) are paid for you. If you enroll in family coverage, your family members' covered medical expenses all accumulate towards the family deductible. The entire family deductible must be met before any benefits (except preventive care) are paid for any family member.

Who is eligible for a health savings account?

You are eligible to open and contribute to a health savings account if you:

- Are enrolled in a qualified high deductible health plan.
- Are not enrolled in Medicare.
- Are not enrolled in another health plan, such as a spouse's plan.
- Are not claimed as a dependent on someone else's tax return. (However, spouses may open their own HSAs, if otherwise eligible.)

What are “qualified medical expenses”?

HSA distributions are not taxable if they are used to pay for qualified medical expenses. Qualified medical expenses include your out-of-pocket costs for services covered by your HDHP, such as office visits and hospital services. They also include prescription medications, vision expenses (eyeglasses and contact lenses), and non-cosmetic dental expenses. Qualified medical expenses are further defined by the IRS in Publication 502: <http://www.irs.gov/pub/irs-pdf/p502.pdf>. Please note that your health plan premium is not a qualified medical expense, except when it is for qualified long-term care coverage, health-care continuation coverage required by federal law, or health-care coverage while you are receiving unemployment compensation.

What if I use my HSA funds for “non-qualified” expenses?

Individuals under age 65 who use their HSA funds for anything other than qualified medical expenses must pay income tax plus a 10% penalty on the amounts withdrawn. Individuals age 65 and over may use HSA funds for non-qualified expenses without penalty; however, the amounts withdrawn are still subject to income tax.

What are the HSA contribution limits?

For 2008, the annual contribution maximum is \$2,900 for single coverage or \$5,800 for family coverage. These limits are pro-rated for individuals who terminate HDHP coverage mid-year. The amounts are indexed for inflation and will likely increase in the future. If you're 55 or older, you may make additional “catch-up” contributions.

What are “catch-up” contributions?

If you're 55 or older and otherwise eligible for an HSA, catch-up contributions allow you to accumulate HSA funds faster in a shorter period of time for qualified medical expenses and retirement. The maximum “catch-up” contribution is \$900 in 2008 and \$1,000 in 2009. Like the annual contribution limits, the maximum catch-up contribution is pro-rated for those who terminate HDHP coverage mid-year.

How often may I contribute to my HSA?

HSA contributions may be made incrementally or in one lump sum. However, if you deposit the maximum contribution amount at the start of the year and terminate your HDHP coverage midway through the year, you will have exceeded your maximum allowable contribution.

Can my spouse and I jointly own an HSA?

No. HSAs cannot be jointly owned under any circumstances.

Can I use my HSA funds for my family's qualified medical expenses?

You may use your HSA funds for your qualified medical expenses, as well as those of your legal spouse and/or dependents, regardless of whether they are covered by your HDHP. Medical expenses for a domestic partner are not HSA-eligible, as the current tax code and the Defense of Marriage Act do not allow domestic partners the same benefits as spouses.

What happens to my HSA if I no longer have coverage under a qualified high deductible health plan?

The funds accumulated in your health savings account belong to you. If you are no longer covered by a qualified high deductible health plan, for whatever reason, you may not make further contributions to your HSA. However, you may continue to withdraw HSA funds, tax-free, for qualified medical expenses.

What happens to my HSA when I turn 65?

You may continue to make tax-free withdrawals for qualified medical expenses. If you are enrolled in Medicare, you may also use your HSA to pay for premiums, deductibles, copays, or coinsurance under any part of Medicare, except for a Medicare supplemental or "Medigap" policy. If you have retiree health benefits through your former employer, you may also use your health savings account to pay for your share of retiree health insurance premiums. Once you reach age 65, you may also use your HSA to pay for non-qualified expenses without penalty; however, the amounts withdrawn will be considered taxable income.

What happens to my HSA when I die?

If you are married, your spouse becomes the account owner and can use it as if it were his or her own HSA. If you are not married, the account will no longer be treated as an HSA upon your death. Instead, the accumulated funds will pass to your beneficiary or estate and will be subject to any applicable taxes.

Special Notices

NOTICE OF PREEXISTING CONDITION EXCLUSION

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only where there was a recommendation or receipt during the plan's look-back period of medical advice, diagnosis, care, or treatment for the condition (Under federal law, the look-back period can be no longer than six months.) Generally, the look-back period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the look-back period ends the day before the waiting period begins.

A preexisting condition exclusion does not apply to a child who becomes covered on a group or individual health

plan within 30 days after birth, adoption, or placement for adoption, unless a period of at least 63 consecutive days without creditable coverage has elapsed. A preexisting condition exclusion cannot apply to pregnancy on a group health plan.

The exclusion period may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a subsequent break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have from previous plans (or from plans that were in force at the time of your enrollment in this plan). If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

YOUR SPECIAL ENROLLMENT PERIOD RIGHTS

If you gain a new dependent as a result of birth, adoption, or placement for adoption, you must request enrollment within 30 days after the birth, adoption, or placement for adoption.

To obtain further information, please contact our Individual Marketing Department at 1 (888) REGENCE (734-3623)

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (WHCRA)

Regence BlueCross BlueShield of Utah and its subsidiaries are required by law to provide you with the following notice. This does not represent a change in your coverage. The Women's Health and Cancer Rights Act of 1998 (WHCRA) includes important protections for patients who elect breast reconstruction in connection with mastectomy.

For a member who receives benefits in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy including lymphedemas.

Benefits for the above services will be subject to the same subscriber cost-sharing provisions (i.e., deductible, copayment and coinsurance) as may be deemed appropriate and as are consistent with those established for other covered services. Your plan is already in compliance with this mandate and provides coverage for this benefit.

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